DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

March 17, 2010

David Rowe, CEO Madison Memorial Hospital 450 East Main Street, PO Box 310 Rexburg, ID 83440

CMS Certification Number: 13-0025

Re: Complaint Control #: 4479 (EMTALA)

Re: Plan of Correction

Dear Mr. Rowe:

The Centers for Medicare and Medicaid Services (CMS) is in receipt of Madison Memorial Hospital's plan of correction dated March 4, 2010, which was submitted on the hospital's behalf by Mr. Kim Stanger. We have determined that Madison Memorial Hospital's allegation of compliance is credible based upon our review of the documentation provided; however we are requesting that the Idaho Bureau of Facility Standards (State agency) conduct a revisit to your facility to ensure full implementation of the corrective actions. The proposed termination action from our February 23, 2010, and March 16, 2010, letters is suspended pending the results of the revisit by the State agency. We will notify you of our final decision once we have the results of the revisit.

We thank you for your cooperation and look forward to working with you on a continuing basis in the administration of the Medicare program. If you have questions regarding this letter, please contact Kate Mitchell, of my staff at (206) 615-2432.

Sincerely,

Steven Chickering Western Consortium Survey & Certification Officer Division of Survey & Certification

cc: Idaho Bureau of Facility Standards

DEPARTMENT OF HEALTH & HUMAN SERVICES



CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
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CORRECTED LETTER IMPORTANT NOTICE – PLEASE READ CAREFULLY



March 16, 2010

David Rowe, CEO Madison Memorial Hospital 450 East Main Street, PO Box 310 Rexburg, ID 83440

CMS Certification Number: 13-0025

Re: Complaint Control # 4479 (EMTALA)

Dear Mr. Rowe:

This letter replaces the Centers for Medicare and Medicaid Services' (CMS) letter dated February 23, 2010. To participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861 (e) of the Act. Further, §1866 (b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

Your hospital was surveyed January 7 – 14, 2010, by the Idaho Bureau of Facility Standards (State Agency) based on an allegation of noncompliance with the requirements of 42 Code of Federal Regulations (CFR) \S 489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases and /or the related requirements at 42 CFR \S 489.20. After a careful review of the findings, we have determined that your hospital violated:

 The requirements of 42 CFR § 489.24(a) based on failure to provide an appropriate medical screening exam;

The deficiencies identified are listed on the enclosed form CMS-2567, Summary Statement of Deficiencies.

The purpose of this letter is to notify you of these violations and advise you that under 42 CFR § 489.53, a hospital that violates the provisions of 42 CFR § 489.20 and/or 42 CFR § 489.24 is subject to termination of its provider agreement. Consequently, it is our intention to terminate Madison Memorial Hospital's participation in the Medicare program. The projected date on which the agreement will terminate is **May 24, 2010**.

You will receive a "Notice of Termination" letter no later than May 7, 2010. This final notice will be sent to you concurrently with notice to the public in accordance with regulations at 42 CFR § 489.53.

You may avoid termination action and notice to the public either by providing credible allegation or credible evidence of correction of the deficiencies, or by successfully proving that the deficiencies did not exist, prior to the projected public information date. In either case, the information must be furnished to this office so that there is time to verify the corrections. An acceptable plan of correction (POC) must contain the following elements:

- The plan of correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its
 improvement actions into its Quality Assessment and Performance Improvement (QAPI)
 program, addressing improvements in its systems in order to prevent the likelihood of the
 deficient practice reoccurring. The plan must include the monitoring and tracking
 procedures to ensure the plan of correction is effective and that specific deficiencies cited
 remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

It is highly recommended that the <u>latest</u> completion date in the plan of correction be no later than **March 25, 2010**. Please submit the POC within 10 days receipt of this letter, to the State survey agency and to the following address:

CMS – Survey, Certification, and Enforcement Branch Attn: Kate Mitchell 2201 Sixth Avenue, RX-48 Seattle, WA 98121 Fax: (206) 615-2088

A credible <u>allegation</u> of correction by the hospital may require a resurvey to verify the corrections. However, when <u>evidence</u> of correction is provided by the hospital, this office must decide whether the evidence of correction is sufficient to halt the termination action. If the evidence is not sufficient in itself to establish that the hospital is in compliance, a resurvey is required for verification of correction.

Page 3 - Mr. Rowe

If we verify your corrective action, or determine that you successfully refuted the findings contained in this letter by proving that allegations were in error, your termination from the Medicare program will be rescinded.

If you have any questions concerning this preliminary determination letter, please contact Kate Mitchell of my staff at (206) 615-2432 or <u>Catherine.mitchell@cms.hhs.gov</u>.

Sincerely,

Steven Chickering Western Consortium Survey and Certification Officer Division of Survey and Certification

Enclosure

cc: Idaho Bureau of Facility Standards Office of Civil Rights (OCR)

Complainant

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		130025	B. WiN	IG_		01/1	4/2010	
	OVIDER OR SUPPLIER MEMORIAL HOSPITAL			4	REET ADDRESS, CITY, STATE, ZIP CODE 450 EAST MAIN STREET REXBURG, ID 83440			
(X4) ID PREFIX TAG			1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
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A2400	Labor Act MD = medical doctor MMH = Madison Mer MSE = Medical Scree MSO4 = morphine su prn = as needed RN = registered nurs 489.20(I) COMPLIAN [The provider agrees defined in §489.24(b) This STANDARD is Based on staff intervirecords and hospital the hospital failed to CFR 489.24(a). The appropriate MSE to 1	om cy Medical Treatment and norial Hospital ening Examination Ilfate	A2	4400				
A2406	MSE provided to a pa 489.24(r) and 489.24 EXAM	(c) MEDICAL SCREENING		406			TOTAL PARTY OF THE	
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sefeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction ere disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued progrem participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETEO		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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